WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

North Staffordshire Health Economy

Visit Date: 9th, 10th, 11th October 2012

Report Date: January 2013

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INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 9th, 10th, 11th October 2012. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1, May 2012
- Care of Children and Young People with Diabetes, Version 1.2, June 2012

and the following national standards:

- Pulmonary Rehabilitation Service Specification, Department of Health, August 2012
- British Association of Cardiovascular Prevention and Rehabilitation, Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation, March 2012

This visit was organised by WMQRS on behalf of the West Midlands Long-term Conditions Care Pathway Group.

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

Care of people with long-term conditions was chosen as the main WMQRS review programme for 2012/13 for a variety of reasons. Six out of 10 adults report having a long-term condition that cannot currently be cured and the majority aged over 65 have two or more long-term conditions. Eighty per cent of primary care consultations and two thirds of emergency hospital admissions are related to long-term conditions. The Operating Framework for the NHS in England 2012/13 gave priority to improving the care of people with long-term conditions. Most services for people with long-term conditions had not previously been subject to external quality assurance. The focus brought to these services by the Quality Standards and peer review visits was therefore new for many staff involved in the care of people with long-term conditions. This review programme has given the opportunity for highlighting good practice and sharing this with others across the West Midlands, as well as identifying areas where action is needed by providers and commissioners.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services at North Staffordshire health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

North Staffordshire was one of the first health economies to be visited in the 2012/13 peer review programme. Compliance with Quality Standards may therefore be lower than in health economies which had a longer period of preparation.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more

confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on http://www.wmqi.westmidlands.nhs.uk/wmqrs

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of North Staffordshire health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

CARE OF PEOPLE WITH LONG-TERM CONDITIONS

HEALTH ECONOMY

General Comments and Achievements

The North Staffordshire health economy was going through a time of considerable change with the new community provider, Staffordshire and Stoke on Trent Partnership NHS Trust, in existence for only a year, two new Clinical Commissioning Groups and the University Hospital of North Staffordshire NHS Trust going through the move into its new building and providing support to Mid Staffordshire NHS Foundation Trust.

Despite the extent of change that was taking place, reviewers commented on the vibrant enthusiasm and commitment to improving the care of people with long-term conditions among everyone they met.

Good Practice

1 **Partnership Working**

Reviewers were impressed by the breadth and depth of partnership working in the North Staffordshire health economy, among health organisations and with social services. Staffordshire and Stoke on Trent Partnership NHS Trust was providing integrated health and social care and the new Integrated Locality Care Teams involved health and social care staff. Integration was apparent at many levels, including in commissioning. Reviewers commented on the culture of transparency and honesty with staff and patients confident to express their concerns and challenge others.

Local networks were being set up to improve pathways of care for people with long-term conditions. These were already working well for the care of people with heart failure and diabetes and were being implemented for other long-term conditions. These networks were focussing on establishing, documenting and then reviewing and improving the integrated local pathway.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Some staff working operationally were not aware of the health economy vision and actions taking place to improve the care of people with long-term conditions. Ongoing attention to communication may be helpful, especially because of the extent of change of staffing in some organisations.

2 Information Technology Systems: Some good progress was being made and reviewers were particularly impressed by the 'Potteries Way' system. This progress did not extend to all services and several different systems were in use in some pathways with paper records forming the basis of Staffordshire and Stoke on Trent Partnership NHS Trust care plans. Staff therefore did not always have access to the latest information about their patients and some staff were spending considerable amounts of time faxing and making phone calls, especially on changes to medication.

3 Given the good progress being made on individual pathways, the health economy may wish to try out approaches to improving the care of people with multiple long-term conditions and to improving coordination between pathways for people with the most complex needs.

4 Several members of staff commented to reviewers about changes to the activity, bed and resource assumptions at University Hospitals of North Staffordshire NHS Trust and the implications of these for other services locally. It was generally understood that some of the retained estate may continue to be used for patient care but the reasons for this were less well understood. There appeared the potential for myths to

develop and spread. Reviewers suggested that a health-economy wide update of the *Fit for the Future* assumptions and communication to staff about this may be helpful.

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PRIMARY CARE

STOKE ON TRENT CLINICAL COMMISSIONING GROUP AND NORTH STAFFORDSHIRE CLINICAL COMMISSIONING GROUP

General Comments and Achievements

See health economy section of this report about the progress being made of partnership working. There were also good arrangements for primary care education and training in Stoke on Trent. These were not as well-established in North Staffordshire but this was known and understood and actions were being taken to improve arrangements.

Good Practice

1 Reviewers were particularly impressed by the arrangements for early identification of patients with long-term conditions, case-finding and risk stratification. This work had started with the BUPA risk stratification tool and had moved on to the development of another system, in conjunction with the University of Keele. This work had also included identification of the patients of greatest concern to the GPs.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified**.**

Further Consideration

1 Some of the specialist services for people with long-term conditions were not aware of the risk stratification information that was available. Greater communication with specialist teams about this may be helpful.

2 Several of the individual pathway sections of this report include comments about improving the links between specialist teams and primary care: Links with primary care and community nursing services may benefit from further consideration in order to maximise the use of the skills in primary care services, ensure good handover from specialist services and easy routes to re-access more specialist advice and care if this is required. Specific issues were raised in relation to the care of people with epilepsy and in relation to early identification of possible complications for people with diabetes.

3 The work on a primary care education and training programme for North Staffordshire CCG needs to continue.

4 It may be helpful to audit that arrangements for follow up of women with gestational diabetes have been implemented in all practices.

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SPECIALIST CARE OF CHILDREN & YOUNG PEOPLE WITH DIABETES

UNIVERSITY HOSPITALS OF NORTH STAFFORDSHIRE NHS TRUST

General Comments and Achievements

Patients and their families gave good, positive feedback on the care they received from the paediatric diabetes team at University Hospital of North Staffordshire, for example, one comment was: 'I felt empowered after a clinic visit'. The team was enthusiastic and positive. The new ward and out-patient facilities were excellent.

The rate of hospital admission was low. An insulin pump service had been established and a dietetic service developed. A parent support group was run and was very popular.

Good Practice

1 Paediatric diabetes specialist nurses were available from 8am until 8pm. This was very much appreciated by parents because it helped to minimise disruption to the children's schooling and to their work and, possibly, also helped to avoid admissions.

Immediate Risks: No immediate risks were identified.

Concerns

1 The information given to newly diagnosed patients was not comprehensive or consistent. Ward staff were not able to show what would be included in a 'pack' for the newly diagnosed patients and their families, and the available information seen by the reviewers was limited. A new booklet was in development which will improve this but still did not cover all relevant aspects.

2 Advice given over the telephone by paediatric diabetes specialist nurses was not routinely, clearly documented.

3 The service had made little progress towards achieving the *Best Practice Tariff* which could have significant consequences for funding. An analysis of the gap between the current service and that needed to meet *Best Practice Tariff* had not yet been undertaken.

Further Consideration

1 Further work on the content and presentation of clinical guidelines would be helpful. Some of the guidelines seen by reviewers were inconsistent, several were in paper form only and not available on the Trust intranet and some lacked appropriate detail.

2 At the time of the review 22 different blood glucose meters were in use by families. A programme of work to reduce this number was taking place and reviewers supported continuation of this work.

3 Some patient and carer feedback about staff attitudes may benefit from further consideration – with the aim of ensuring all staff of the service are taking a supportive, non-judgemental and enabling attitude to children, young people and their families.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

Staffordshire and Stoke on Trent Partnership NHS Trust was in the process of implementing Integrated Local Care Teams (ILCT) across Stoke on Trent and North Staffordshire. Four 'early implementer' sites had been established using a coordinated case management model and the WMQRS review focussed on these teams. Key outcome and performance metrics were in the process of being developed. The Trust and commissioners were also piloting the Year of Care Funding Model for people with long-term conditions.

Reviewers considered that the model of care had the potential significantly to improve care for people with long-term conditions. The full development and roll-out to other areas was supported by the visiting team. Staff providing the service were aware that further work was needed and were keen and enthusiastic to develop and implement the model further.

The multi-disciplinary approach included a 'core team' of community nursing staff, GP's, practice staff, and social workers with some teams also having a community psychiatric nurse and voluntary sector involvement. The ILCT

vision included the integration of therapists and rehabilitation workers within each team. The teams were working towards integrated, multi-disciplinary assessments, care plans and personal care. They had achieved integration with social care.

All patients of the ILCTs had a patient-held record which included carbonated record sheets so that a copy of every entry was held at the base and served as a chronological record of the patients journey.

Good Practice

1 Multi-disciplinary meetings were held involving health and social care ILCT staff and specialist nurses from condition-specific teams when they were involved with the care of the patient.

2 The 'Potteries Way' communication system enabled easy communication between general practices, ILCTs, community nursing teams and specialist teams.

3 ILCT staff had immediate access information about acute admissions, including imaging and pathology results.

4 A good training programme was in place for ILCT staff. This was well-organised and covered nearly all the expected aspects of the care of people with long-term conditions.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Reviewers commended the vision and plans for the ILCTs. It will be important to ensure that the current momentum is maintained so that the 'early implementer' sites progress to full implementation and the model is rolled out to the other parts of North Staffordshire and Stoke on Trent. As part of this work, reviewers suggested that particular attention should be paid to a) providing written information for patients, b) documenting guidelines and procedures about how the service is to run and c) clearly identifying the care coordinator for each patient.

2 The self-management and self-care aspects of the ILCTs work may benefit from further consideration to ensure that patient goals and the actions patients will take to achieve these goals are embedded into all aspects of the teams' work. It may also be helpful, as part of this work, to identify the triggers which can lead to discharge from the service and triggers for re-accessing ILCT care.

3 The patient-held record provided a good summary for professionals. In taking forward the service, it may be helpful to include patient goals and patient actions, to work with patients on whether the record could be more patient-friendly and to consider the potential for an electronic record.

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Specialist Care of Adults with Diabetes

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST & UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

General comments

Services for adults with diabetes were provided by the Diabetes and Endocrinology Department at University Hospital of North Staffordshire NHS Trust working with the Community Diabetes Team at Staffordshire and Stoke on Trent Partnership NHS Trust. Both services were well-organised and worked well together. Reviewers met a wide range of staff as part of the review and were grateful for their openness and willingness to discuss the service. Clinical competence and a focus on patient-centred care were evident through these discussions. The team was aware of limitations in the services provided and worked hard to manage the high number of patients

with diabetes in an economically deprived area. Staff were also looking to implement the guidelines issued from Diabetes UK regarding end of life care for patients with diabetes and other complications.

Achievements

1 A local Diabetes Network had recently been formed with good engagement from all relevant stakeholders. This local Network provided an excellent forum to take forward future service developments.

2 A high level of 'Think Glucose' implementation had been achieved with very good charts on the wards which showed the progress achieved.

3 The development of adjacent male and female wards had allowed for an expansion of the service and ensured that patients with diabetes and endocrine disorders were usually able to be cared for by staff with specialist expertise in these services.

4 A public engagement event had been run in collaboration with Diabetes UK and had attracted over 70 people.

5 A pilot of self administration of insulin was being run on the ward.

Good practice

1 Guidelines for acute exacerbations and acute complications were clear, comprehensive and well-structured.

2 Ward care for people admitted with wounds that needed dressing was well organised. The wards had 'grab packs' to enable easy access to required equipment, and tissue viability champions. The wards visited were also actively engaged in health promotion and had a focus on reflective learning.

3 A good range of more specialist clinics were running including a Gestational Diabetes Mellitus clinic, which had very clear guidelines, a monthly transition clinic, joint renal and diabetic foot clinics. Patient feedback on the transition clinic was very good. The diabetic foot clinic was run jointly with the diabetes specialist podiatrist and in parallel with the vascular surgery clinic.

4 The Specialist Tier 3 service in primary care was very good. The service was provided by 'hubs' located in each neighbourhood / locality area. Each differed according to the identified needs of the area and some included diagnostic services and /or community beds. All the hubs provided community specialist multidisciplinary outpatient services as well as home visiting. The specialist advice available meant that admissions to the acute hospital could be avoided.

Immediate Risks: No immediate risks were identified.

Concerns

1 Information Technology: Acute and community IT systems did not communicate with each other and so staff could not see the patients' most up to date plan of care. Community staff could see some information about imaging and pathology results and details of hospital admissions but acute staff could not access records of the care provided by the community team.

2 Dietician staffing levels were low for the number of patients, especially in North Staffordshire and only one dietetic clinic could run per month.

3 Inpatients did not have access to podiatric debridement for wound care. This was available in clinic but not for inpatients.

See also issues relating to the commissioning of services for people with diabetes identified in the commissioning section of this report.

Further Consideration

1 Reviewers were told that patients had a relatively high level of complications such as amputation, renal disease and retinopathy. Earlier detection and referral to specialist services may help to reduce the level of complications. The service was actively contributing the GP education programmes in Stoke on Trent but not yet in North Staffordshire. Further consideration of the potential of contribution to prevention, early detection programmes and to the education and training of primary care and long-term care providers may be helpful.

2 The arrangements for Identifying a specific care-coordinator may benefit from review to ensure that patients always had a nominated person who they could contact for advice.

3 Care plans were not formalised and did not include clear patient-defined goals.

4 Feedback from patients was gathered and discussed at meetings but there was no evidence that patient comments informed service development. Also, although it was clear that mechanisms for review and learning were in place, it may be helpful to ensure that the lessons learnt are shared across the health economy.

5 A diabetes register had previously been held by the PCT and had moved to an individual practice basis. The implications of this for local services' ability to support the care of people with diabetes may benefit from further consideration.

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SPECIALIST CARE OF PEOPLE WITH COPD

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST & UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

General Comments and Achievements

Specialist care for people with chronic obstructive pulmonary disease was provided by a community respiratory team (Staffordshire and Stoke on Trent Partnership NHS Trust) and an acute team (University Hospital of North Staffordshire NHS Trust). The community respiratory team provided an integrated advice, assessment, education and rehabilitation service. Home oxygen assessment, early supported discharge and domiciliary chest physiotherapy were also provided for patients from Stoke on Trent. Six community consultant clinics were provided at a four different locations and patients could be seen urgently in these clinics (Monday to Friday). The acute team consisted of a consultant, three specialist nurses and a physiotherapist. The team identified patients admitted through the emergency 'portals' of the hospital on a daily basis (Monday to Friday) and identified patients with a confirmed or suspected diagnosis of COPD. The acute team provided specialist support during admissions, including advising on inhaler technique, symptom control and management of exacerbations. The team linked with the community respiratory team and community matrons. An active acute non-invasive ventilation service was provided for appropriate patients. The home ventilation team provided post-discharge support for a large number of patients from across Staffordshire, Shropshire and other areas.

Reviewers were very impressed by the high standard of care offered to individuals with COPD and by the enthusiasm, drive and progress of the service that had been achieved by the acute and community teams. The teams had a clear vision for the delivery of care for people with COPD that was shared by all those involved in the service. The teams were also actively working with commissioners to address historical differences in the commissioning of services.

Good Practice

1 Reviewers were impressed by the integration between acute and community teams and by many aspects of the COPD pathway. Of particular note were the provision of community-based consultant clinics and community spirometry, the integrated pulmonary rehabilitation service, the early supported discharge service and the in-patient non-invasive ventilation service. There was evidence that the community focus of the pathway had avoided admissions and reduced length of stay in hospital.

2 The home ventilation service was highly developed and provided support to a large number of patients from a wide area.

3 A weekly MDT was held which discussed patients in need of further management and provided advice to primary care. This had been shown to reduce the need for these patients to attend clinics.

Immediate Risks: No immediate risks were identified.

Concerns

1 Reviewers were seriously concerned that about level staffing for the home ventilation service. At the time of the review two nurses were supporting the care of 600 patients on home ventilation, 10 of whom were receiving invasive home ventilation, and a further 200 patients at risk of developing respiratory failure (mostly with Neuromuscular disease) . University Hospital of North Staffordshire was in the process of appointing an additional nurse for the team brining the staffing level up to three, however the review team felt that this would still be suboptimal for the number of patients under their care. The review team also felt that the level of Medical Cover for the home ventilation team was sub optimal, and was significantly below levels recommended by the Royal College of Physicians given the workload of the Team and the complexity of patients under their care (RCP recommend 1 PA per 50 patients on NIV). Consultant Anaesthetist time to help care for the invasively ventilated patients would also benefit from review to ensure that appropriate sessional time was available.

2 Home oxygen assessment and review service for patients from North Staffordshire: See commissioning section of this report.

Further Consideration

1 Administrative and clerical support was insufficient for the needs of the service. The acute Trust COPD team had had no clerical support since 2011. Clerical support within the community team was also insufficient but plans were in place to address this. As a result, clinical staff were spending unreasonable amounts of time on administrative and clerical work.

2 The skill mix of the COPD teams may benefit from review. Reviewers suggested that it may be possible to make more use of nurse-led clinics and health care assistants for some aspects of the teams' work. This could free up time of more senior clinical staff for other work, including for education, training and development of staff in a variety of settings.

3 Some training and education for primary care and community staff had been provided in the past but there was no ongoing programme. Patients who met reviewers also commented on some lack of awareness of COPD among staff on non-respiratory wards when they were admitted to hospitals. Further consideration of meeting the COPD-related education and training needs of primary care, ILCT and acute ward staff may be helpful. This may also help to support discharge from the respiratory team.

4 The care plans may benefit from more patient involvement in goal setting and greater clarity about the actions that patients themselves are taking to achieve these goals.

5 Reviewers were told that the home ventilation service faced some difficulties with compatibility of equipment. Reviewers did not have time to explore this issue in detail.

6 The patient information did not yet include an overview of the whole COPD pathway and of the services available. Greater patient involvement in designing the written information may also be helpful.

7 Patients who met the reviewers commented that access to the hospital and some community clinics was difficult because of the distances they had to walk. The acute Trust had purchased golf buggies, which the patients were aware of, the patients were concerned about who would help them to use these and how this would work at busy times. A review of access for patients likely to become breathless may be of benefit.

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SPECIALIST CARE OF PEOPLE WITH HEART FAILURE

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST & UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

General Comments and Achievements

Services for people with heart failure were provided by an acute care team from University Hospital of North Staffordshire NHS Trust and a community team from Staffordshire and Stoke on Trent Partnership NHS Trust. These staff worked well together as an energetic and committed team who were fully aware of what they need to achieve. The service was re- launched in 2007 with additional investment. Clear leadership of the service was driving developments and improvements in the care offered. Heart failure specialist nurses linked with GP practices as well as having a service-wide role.

Primary care referral guidelines were clear and well thought through. Good training and development programmes for in place for primary care staff, including 'Top Tips'. The achievements of the service had been recognised in several awards.

Good Practice

1 There was a strong culture of measuring all aspects of the service provided and actively using this information to improve and develop the quality of care offered.

2 The integrated Ambulatory Heart Failure Clinic provided specialist treatment for patients who did not need, or would prefer not, to be hospitalised. Patients could self-refer to this service if they had previously been seen by the cardiology team. The team had collected data which showed 60 % of patients had been able to be cared for and died in their preferred place of death compared with 6 % in previous years.

3 Patients used a 'traffic light' system to identify when they should contact the service for advice. They could self-refer based on the assessment on the alert sheet. Patients who met the visiting team were very positive about the confidence which this gave them in managing their own care. Use of the alert sheet had also been shown to lead to a reduction in hospital bed days used by people with heart failure. The condition alert sheet was very clear about who and when to contact for advice. Patients who met with the visiting team were very positive about its use.

4 Heart failure multi-disciplinary team meetings had regular input from one of the palliative care consultants. This was particularly helpful in supporting the care of people at home and avoiding hospital admissions.

5 Daily review of all echocardiograms was used as a method of proactive case-finding.

Immediate Risks: No immediate risks were identified.

Concerns

1 Access to psychological therapies was not easy. Patients had to be referred back to the GP and then re-referred. There were then delays before patients could be seen. The Vascular Health and Well-Being

service was available but this was not always appropriate for the heart failure patients because of the frequency of depression in this patient group.

2 The patient was not always given a copy of their latest care plan. IT systems did not allow all members of the heart failure service to see the latest care plan and to see relevant records held by the other organisation. Community care plans were paper-based. Patients therefore had multiple care records and no-one, including the patient, had all the up to date information.

Further Consideration

1 The North Staffordshire community service did not have the capacity to see all newly referred patients within seven days because of limited staffing (1.2wte to cover all North Staffordshire). It may be helpful to develop an integrated workforce plan for the combined service, including the implications for echocardiography.

2 Links with primary care and community nursing services may benefit from further consideration in order to maximise the use of the skills in primary care services, ensure good handover from specialist services and easy routes to re-access more specialist advice and care if this is required.

3 The Ambulatory Heart Failure Clinic was being re-commissioned at the time of the review visit. Attendances were increasing and the service was often seeing 11-13 patients per day. It will be important to ensure that, when re-commissioned, this service continues to have the capacity to meet the demand and link effectively with the acute and community heart failure services.

4 Further evaluation of the impact of the tele-health care may be helpful to ensure that it is meeting the needs of patients.

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SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS

UNIVERSITY HOSPITAL NORTH STAFFORDSHIRE NHS TRUST – ACUTE SERVICE

General Comments and Achievements

University Hospital of North Staffordshire provided an acute neurology service, with in-patient and day case facilities, out-patient clinics and outreach on a 'hub and spoke' model into Cheshire and to Stafford Hospital. The services were well organised and staff were enthusiastic and well informed. Team-work was good and the quality of support from the specialist nurses was commended by all of the patients who met the visiting team. There was a culture of working to improve the services offered and particular developments at the time of the review visit were the use of tele-medicine for patients with chronic neurological conditions and the waiting times for new out-patient referrals were three weeks and very nearly reaching the NICE guidance of two weeks.

Good Practice

1 Portable video-telemetry was being used for the diagnosis of epilepsy. This provided a cost-effective approach to reducing the mis-diagnosis of epilepsy.

2 Service improvement had been effectively used to manage out-patient capacity and demand. In particular a 'zero backlog' approach had been used for out-patient follow-up. This was actively monitored and managed. Data on the shortfall in capacity had led to the recruitment of two part-time consultants.

3 Good arrangements were in place to enable people with severe disabilities to attend out-patient appointments, including good coordination with the ambulance service and availability of pressure-relieving mattresses.

4 The 'nurse call' system had been adapted with a specialised pressure switch system so that it could be used by people who were severely neurologically impaired.

5 The layout of the neurological infusion suite was well-planned, with a private nurse assessment area which led into a treatment delivery area.

6 All the clinical nurse specialists were independent prescribers.

Immediate Risks: No immediate risks were identified.

Concerns

1 There were delays in telephone access to advice with some patients reporting that they were not called back for up to three weeks. Patients who met with the visiting team commented that this had occurred since the changes to the reduction in specialist nursing hours.

2 Accessibility for wheelchair users was difficult with no automated doors in the out-patient or ward area. Also the self check-in machines in the out-patient department were not at a height suitable for people in wheelchairs.

3 See also the commissioning section of this report about care of people with epilepsy.

Further Consideration

1 Some patients had neurological conditions that were not covered by the clinical nurse specialists available at the time of the review and so did not have access to the same level of support. Approaches to providing specialist nursing support for these patients may benefit from further consideration. Also, at the time of the review, specialist nurse activity appeared to focus on pharmacological interventions. It may be helpful to review, with patients and carers, whether holistic support needs are being met.

2 The rooms allocated for out-patient clinics varied which made it difficult for staff to have all the appropriate educational material available.

3 Links with primary care and community nursing services may benefit from further consideration in order to maximise the use of the skills in primary care services, ensure good handover from specialist services and easy routes to re-access more specialist advice and care if this is required. This was specifically raised with reviewers in relation to the care of people with epilepsy.

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST – COMMUNITY AND IN-PATIENT REHABILITATION

General Comments and Achievements

Staffordshire and Stoke on Trent Partnership NHS Trust provided a Rehabilitation Medicine Service and a Community Rehabilitation Team which together formed the North Staffordshire Rehabilitation Centre. The North Staffordshire Rehabilitation Centre was a regional resource covering Staffordshire, Shropshire, Cheshire and a small area of North Wales. The Community Rehabilitation Team covered part of North Staffordshire (around the Newcastle Under Lyme area). Specialist rehabilitation was available in both in-patient and community settings. Facilities were geared to provide support for those patients with an acquired brain injury and severe and complex neurological conditions, as well as for those with long term conditions.

Reviewers were impressed by the range of services available and the highly personalised care aimed at enabling service users to maintain and increase their independence and participation in society. Feedback from patients and carers, especially about the in-patient care, was excellent. The service took a holistic approach to meeting patients' needs. There was good patient involvement in the running of the service, including in the design of patient information.

Good Practice

1 Carers support at the Haywood Hospital was particularly good. Carers felt that their needs were assessed and taken into account. Flexible visiting was available for Carers with relatives who needed to stay for long periods of time and the service also provided respite care.

2 There were excellent relationships developed by both teams with adult social services.

Immediate Risks: No immediate risks were identified.

Concerns

1 Psychological support was not available on the rehabilitation ward. At the time of the review, physiotherapy and occupational therapy was insufficient for the number of patients being cared for by the service, partly due to staff vacancies.

2 See commissioning section of this report about care of people with epilepsy.

Further Consideration

1 Patients who met with the visiting team commented that there were often delays in communicating prescription changes between specialists and GPs.

2 See commissioning section of this report about access to neurological rehabilitation services

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TRUST-WIDE

UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

The care of people with long-term conditions peer review programme looked at care pathways, including those into acute services, and so did not look in detail at Trust-wide issues, but the following comments were made in relation to the care of people with long term conditions.

Good Practice

1 Quality Nurses were being introduced on all acute wards. These nurses were given specific time and responsibility for improving quality. The initiative aimed to empower staff to take responsibility for quality issues.

Further Consideration

1 Some comments were made that staff on non-specialist diabetes wards were not always aware of patients particular needs and issues relating to insulin management. If this is case then assurance that staff have the competences to manage patients with diabetes would benefit from being strengthened.

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST

Trust-wide issues relating to Staffordshire and Stoke on Trent Partnership NHS Trust are included in the report of the review of South Staffordshire (West) health economy.

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COMMISSIONING

STOKE ON TRENT CLINICAL COMMISSIONING GROUP AND NORTH STAFFORDSHIRE CLINICAL COMMISSIONING GROUP

The issues identified in the 'health economy', 'primary care' and provider sections of this report will require the attention of commissioners. The following specific points about commissioning were made by reviewers:

General Comments and Achievements

Reviewers were impressed by the commitment and enthusiasm for improving care of people with long-term conditions among commissioners. There was a good vision and determination to drive improvements. Patient participation was good with a range of mechanisms for patient involvement being pursued, including ensuring that all business cases have patient involvement before they were considered.

Good Practice

1 **Needs Assessment**

There was a good locality-based approach to needs assessment. Needs assessments had been undertaken for five localities in North Staffordshire and three in Stoke on Trent. This locality focus was then reflected in the CCG Joint Strategic Needs Assessments. Innovation funding was available for localities to address specific issues. Commissioners were also very aware of 'hidden communities' and were proactively trying to find out and address their needs.

2 **Federated working between CCGs**

The two Clinical Commissioning Groups were committed to learning from the past and taking forward the good aspects of previous commissioning arrangements. There was also a strong commitment to reducing duplication and a formal agreement on Federation had been approved by both CCG Boards. Work had taken place to improve the relationship between the two CCGs and there was a mature approach to cooperation and the need to work together as a health economy. The CCGs were also working with both Local Authorities with the aim of ensuring synergy and reducing duplication.

3 **Early identification of patients with long-term conditions, case-finding and risk stratification:** See primary care section of this report.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Care of People with Epilepsy**

The chronic neurological conditions strategy and service specifications did not include care of people with epilepsy (although an epilepsy specialist nurse was in post at University Hospital of North Staffordshire NHS Trust). Commissioners should ensure that appropriate specialist services are commissioned for people with epilepsy.

2 **Diabetes Services**

A relatively small number of insulin pumps (30) were commissioned by Stoke on Trent CCG and North Staffordshire CCG commissioned insulin pumps on an individual patient basis. There were also differences between the two CCGs in the commissioning of primary care education and telehealth. As a result, providers of diabetes services were having to provide a different quality of service to patients depending on their CCG of residence. Future plans for commissioning of insulin pumps need to be clarified so that appropriate staffing to support these patients can be in place.

Further Consideration

1 **Home oxygen assessment and review service – North Staffordshire CCG**

A full home oxygen assessment and review service was not available for all patients from North Staffordshire at the time of the review. Commissioners were aware of this and were in the process of re-specifying and tendering this service. Communication with respiratory services about the procurement exercise may also be helpful so that they can ensure relevant patients are kept fully informed.

2 **Rehabilitation Services**

Access to community neurological rehabilitation was available only to patients from the Newcastle under Lyme and Kidsgrove areas. Patients in other areas did not have access to this service. Commissioners were aware of this and were in the process of commissioning a community rehabilitation service for other parts of the health economy. A neurology 'Early Supported Discharge' Team was commissioned by Stoke on Trent Clinical Commissioning Group to facilitate discharge home from in-patient facilities. This service was not available to North Staffordshire Clinical Commissioning Group patients.

3 **Paediatric Diabetes**

A Local Network (or equivalent) with responsibility for the care of children and young people with diabetes and involvement of young people, families and relevant local organisations was not yet in place.

4 Some of the service specifications seen by reviewers did not include Key Performance Indicators (KPIs) and, when KPIs were present, they were sometimes very generally worded. Providers commented that they sometimes could not provide data expected by KPIs.

5 Care of People with Multiple Long-Term Conditions: See health economy section of this report.

6 The care of people with more common chronic neurological conditions is described in this report. Less common neurological problems, when considered together, affect a significant number of people. Services for this group of patients are usually less well organised than those for people with more common conditions and further consideration should be given to whether local services are meeting their needs.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Kimara Sharpe	Director of Community Engagement & Primary Care	NHS Dudley

Visiting Team

Kate Ansell	Patient Representative	Shropshire Patients' Group
Helen Bladon	Diabetes Service Lead	Walsall Healthcare NHS Trust
Elsa Davies	Respiratory Team Leader	Shropshire Community Healthcare NHS Trust
Ben Ellis	Physiotherapy Team Lead	Walsall Healthcare NHS Trust
Sian Finn	Self Care Programmes Manager	West Mercia Cluster
Jane Freeguard	Head of Medicines Management & Pharmacy	NHS Worcestershire PCT
Dr Colin Gelder	Respiratory Consultant	University Hospitals Coventry & Warwickshire NHS Trust
Wendy Godwin	Programme Manager for Planned & Unscheduled Care	Walsall Healthcare NHS Trust
John Grayland	Senior Strategy and Redesign Manager - LTC	NHS Birmingham East & North PCT
Narinder Kular	Nurse Consultant Children with Complex Care	Shropshire Community Healthcare NHS Trust
Sharon Letissier	MS Nurse Specialist	University Hospitals Birmingham NHS Foundation Trust
Dr Kathryn McCrea	Consultant Paediatrician	The Shrewsbury and Telford Hospitals NHS Trust
Dr Anand Mohite	Consultant Paediatrician	The Dudley Group NHS Foundation Trust
Dr Devaki Nair	GP Partner & CCG Board member	NHS Walsall PCT
Dr Kiran Patel	Consultant Cardiologist	Sandwell & West Birmingham Hospitals NHS Trust
Dr Vinod Patel	Consultant Diabetologist	George Eliot Hospital NHS Trust
Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust

Dr Steve Sturman	Consultant Neurologist, Neurology and Rehabilitation	University Hospitals Birmingham NHS Foundation Trust
Dr Suresh Upputuri	General Practitioner	Forum Health Centre, Coventry
Dr Martina Walsh	Consultant in Rehabilitation Medicine	NHS South Birmingham PCT
Merleen Watson	User Representative	Diabetes UK
Maggie Williams	Senior Nurse Lead - Community Heart Failure Team	The Dudley Group NHS Foundation Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Quality Manager	West Midlands Quality Review Service
Sue McIldowie	Long Term Conditions Programme Support	West Midlands Quality Review Service
Sharon Ensor		West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Care of Children and Young People with Diabetes			
Primary Care	3	2	67
Specialist Care of Children & Young People with Diabetes	29	18	62
Trust-Wide: University Hospital of North Staffordshire NHS Trust	4	3	75
Commissioning	7	3	43
Health Economy	**43**	**26**	**60**
Care of Adults with Long-term Conditions			
Primary Care	8	3	38
Community Long-term Conditions Services	50	29	58
Specialist Care of Adults with Diabetes	61	40	66
Specialist Care of People with COPD	58	40	69
Specialist Care of People with Heart Failure (All Services)	82	55	67
Heart Failure	(57)	(37)	(65)
Cardiac Rehabilitation	(25)	(18)	(72)
Specialist Care of People with Chronic Neurological Conditions (All Services)	115	83	72
Acute Service	(57)	(37)	(65)
Community and In-patient Rehabilitation	(58)	(46)	(79)
Trust-Wide: University Hospital of North Staffordshire NHS Trust	7	3	43
Commissioning	12	11	92
Health Economy	**393**	**264**	**67**

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